

REC'D Aug 6 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 399

24313

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 1002
(b) Township Ray Mo. Primary Registration District No. 2818
(c) City General Hoop #2 (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 1701 1/2 12th St. (If nonresident, give city or town and State)
(Usual place of abode, no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-8-1938

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 0 0 30

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K.C. Mo.13. NAME Buster Bailey14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No record15. MAIDEN NAME Alice M. Birch16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.17. INFORMANT (ADDRESS) Record Clerk18. BURIAL, CREMATION, OR REMOVAL PLACE Deeds Cemetery DATE 7-14-3819. FUNERAL DIRECTOR (NAME) (ADDRESS) West, Appleton Jones
1905 V St20. FILED 7-13-38 M. M. Crowe, Corp. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-8-3822. I HEREBY CERTIFY, That I attended deceased from 7-8-38 to 7-8-38

I last saw her on 7-8-38 Death is said to have occurred on the date stated above, at 7:00 P.M.

The principal cause of death and related causes of importance were as follows:

Premature Infant
(6 Mos) 159

Other contributory causes of importance:

Name of operation Clinical Date of To
What test confirmed diagnosis Clinical Were an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____ 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____
(Signed) J. O. Dwyer, M.D.
(Address) General Hoop #2

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

D. H. West

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

D. H. West

Licensed Embalmer No.....

2710

P. O. Address.....

1905 Vine

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.